DEPARTMENT FOR MEDICAID SERVICES

MEDICAID REIMBURSEMENT MANUAL FOR HOSPITAL INPATIENT SERVICES

June 2002

Cabinet for Health Services
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621-0001

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SECTION 100. INTRODUCTION

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A prospective payment system for hospitals providing inpatient services for Medicaid recipients, to be reimbursed under the Kentucky Medicaid Program (program) for the Department for Medicaid services (department), is presented in this manual. If not otherwise specified, this system utilizes allowable cost principles of the Title XVIII (Medicare) Program. This payment method is designed to achieve three major objectives: 1) to assure that needed inpatient hospital care is available for eligible recipients and indirectly to promote the availability of this care of the general public, 2) to assure program control and cost containment consistent with the public interest, and 3) to provide an incentive for efficient management. Under this system, payment shall be made to facilities on a prospectively determined basis for inpatient care with no year-end cost settlement required. Except as otherwise indicated in this Medicaid Reimbursement Manual for Hospital Inpatient Services, the basis of this prospective payment shall be the most recent Medicaid cost report (HCFA-2552) available as of November 1 of each year, trended to the beginning of the rate year and indexed for inflationary cost increases which may occur in the prospective year.

In addition, a maximum upper limit shall be established on all inpatient operating costs exclusive of capital costs and professional component costs. For purposes of

applying an upper limit, hospitals shall be peer grouped according to bed size with allowances made in recognition of hospitals serving a disproportionate number of poor patients. Another feature of the prospective system is a minimum occupancy factor by peer group applied to capital costs attributable to the Medicaid Program.

If unaudited data is utilized to establish the universal rate, the rate shall be revised when the audited base year cost report is received from the fiscal intermediary or an independent audit firm under contract with the Department for Medicaid Services.

The payment system is designed to provide for equitable payment levels for the various peer groups of hospitals, and assure that services are provided in conformity with applicable state and federal laws, regulations, and quality and safety standards.

SECTION 101. PROSPECTIVE RATE COMPUTATION

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The prospective system is based on a universal rate year. The rate for the universal rate year shall be set for all hospitals using the most recent cost report data available as of May 1 of each year, trended to the beginning of the rate year and indexed (adjusted for inflation) for the rate year except as otherwise specified in 907 KAR 1:013 and this manual. Rates based on unaudited data shall be revised when an audited base year cost report becomes available to the department. Prospective rates include both inpatient routine and inpatient ancillary costs and shall be established taking into account the following factors:

A. Allowable Medicaid inpatient cost and Medicaid inpatient days based on Medicare cost finding principles shall be utilized. Medicaid inpatient operating costs, excluding Medicaid inpatient capital costs and Medicaid professional component costs, shall be trended to the beginning of the rate year. The Medicaid inpatient capital cost is later used in determining a capital cost per diem. The Medicaid inpatient professional component costs shall be trended to the beginning of the rate year separately from the inpatient operating costs;

SECTION 101. PROSPECTIVE RATE COMPUTATION

B. Medicaid inpatient capital costs based on Medicare cost finding principles shall be utilized except that Medicaid inpatient building and fixtures depreciation cost is defined as sixty-five (65) percent of the amount reported for building and fixtures.

C. Allowable Medicaid inpatient operating costs, excluding those fixed costs associated with capital expenses and professional component costs, shall be increased by the hospital inflation index to project current year inpatient operating costs;

D. A Medicaid inpatient operating cost per diem shall be computed utilizing the Medicaid inpatient operating cost and Medicaid inpatient days;

E. An upper limit shall be established on inpatient operating costs at the weighted median inpatient cost per diem for hospitals in each peer group, except as otherwise specified in Section 102. For purposes of applying an upper limit, hospitals shall be peer grouped according to licensed bed size. The peer groupings shall be: 0-50 beds, 51-100 beds, 101-200 beds, 201-400 beds, and 401 beds and up. Peer grouping shall be based on the number of licensed beds in accordance with 907 KAR 1:013 Section 10(1);

SECTION 101. PROSPECTIVE RATE COMPUTATION

F. A Medicaid inpatient capital cost per diem shall be computed using Medicaid inpatient capital costs and Medicaid inpatient days.

Allowable Medicaid capital costs shall be reduced if the minimum occupancy factors are not met:

1. A sixty (60) percent occupancy factor shall apply to hospitals with 100 or fewer beds.
2. A seventy-five (75) percent occupancy factor shall apply to hospitals with 101 or more beds.

G. Allowable Medicaid professional component costs shall be increased by the hospital inflation index to project current year professional component costs;

H. A Medicaid inpatient professional component cost per diem shall be computed utilizing the Medicaid inpatient professional component costs and Medicaid inpatient days;

I. For acute care hospitals, except as otherwise indicated in this Medicaid Reimbursement Manual for Hospital Inpatient Services, the allowable rate growth from the prior rate year to the new rate year shall be limited to not more than one and one-half times the Data Resources, Inc. (DR I) inflation amount for the same period; limits shall be applied by component (operating and capital cost components only); rate growth beyond the allowable amount shall be considered unallowable for rate setting purposes;

SECTION 101. PROSPECTIVE RATE COMPUTATION

J. The prospective inpatient rate shall be the sum of the allowable inpatient operating cost per diem, the allowable inpatient capital cost per diem, and the allowable professional component per diem;

K. If a review or appeal decision results in the revision of a rate, any additional operating cost not included in the base year cost report shall be offset by the amount allowed for trending and indexing in the following manner:

1. If the cost increase is incurred prior to the rate year in question, the additional operating cost shall be offset by the amount allowed for trending and indexing.

2. If the cost increase is incurred during the rate year in question, the additional operating cost shall be offset by the amount allowed for indexing.

For the rate year beginning July 1, 1999, the reimbursement rate for acute care and rehabilitation hospitals shall be determined by a rate-on-rate methodology by utilizing a hospital's June 30, 1999, per diem rate that includes operating, professional, and capital cost components, multiplied by the rate of increase of three (3) percent.

SECTION 101. PROSPECTIVE RATE COMPUTATION

Effective with admissions on or after January 1, 2000, reimbursement of all medically necessary admissions shall be made without regard to durational limits. This shall include reimbursement attributable to Medicaid recipients in excess of fourteen (14) days formerly reimbursed through the Kentucky Hospital Care Program (KHCP).
For the rate year beginning July 1, 2000, the reimbursement rate for acute care and rehabilitation hospitals shall be determined by a rate-on-rate methodology by utilizing a hospital's June 30, 2000, per diem rate that includes operating, professional, and capital cost components, multiplied by the rate of increase of two and eight-tenths (2.8%) percent.

For the rate year beginning July 1, 2001,the reimbursement rate for acute care and rehabilitation hospitals shall be the rate in effect on June 30, 2001, and includes operative, professional and capital cost components.

For the rate year beginning July 1, 2002, the reimbursement rate for acute care and rehabilitation hospitals shall be the rate in effect on June 20, 2002, and includes operative, professional and capital cost components.

SECTION 101. PROSPECTIVE RATE COMPUTATION

For the rate year beginning July 1, 2001, the reimbursement rate for a psychiatric hospital shall be the lesser of the rate established pursuant to administrative regulation 907 KAR 1:013E, Section 4 or the rate in effect June 30, 2001.

For the rate year beginning July 1, 2002, the reimbursement rate for state-owned or operated psychiatric hospitals shall be in accordance with the per diem rate setting methodology established in 907 KAR 1:013E, Sections 6 through 13.

For the rate year beginning July 1, 2002, the reimbursement rate for nonstate-owned or operated psychiatric hospitals shall be the rate in effect on June 30, 2002.

SECTION 102. ESTABLISHMENT OF UPPER LIMIT

Section 102. ESTABLISHMENT OF UPPER LIMIT

An upper limit applicable to all inpatient costs, except capital costs and professional component costs, shall be set at the weighted median cost for hospitals in each peer group, with the exception of hospitals serving a disproportionate number of indigent patients. (See Section 102B regarding hospitals determined to meet disproportionate share requirements.)

Rehabilitation hospitals and acute care hospitals providing only rehabilitation services shall be exempted from operating upper limits.

General procedures for setting the upper limit shall be as follows: Utilizing cost reports available as of November 1 of each year for all hospitals, allowable Medicaid inpatient costs, excluding those fixed costs associated with capital expenses, and professional component costs shall be trended to the beginning of the prospective rate year. The trending factor shall be established using the Data Resources, Inc., average rate of inflation applicable to the period being trended. The trending factor thus determined shall be utilized to establish the allowable Medicaid inpatient cost basis for indexing.

The cost basis shall then be indexed for the prospective rate year to allow for projected inflation for the year. The result represents the Medicaid inpatient allowable cost basis for rate setting, which is then converted to a per diem cost utilizing the latest available Medicaid inpatient bed day statistics for each hospital.

SECTION 102. ESTABLISHMENT OF UPPER LIMIT

For purposes of applying an upper limit, hospitals shall be peer grouped according to licensed bed size. The peer groupings for this payment system shall be as follows: 0-50 beds, 51-100 beds, 101-200 beds, 201-400 beds, and 401 beds and up.

The hospital inpatient operating cost per diem shall be arrayed from lowest to highest by peer group. Hospitals exempted from operating upper limits shall not be included in the array(s). Newly constructed hospitals and newly participating hospitals shall be excluded from the arrays until a cost report that contains twelve (12) full months of data is available. The median cost per diem for each of the five (5) arrays shall be based on the median number of patient days. The upper limit for each peer group containing facilities with more than 100 beds shall be computed at the weighted median. The upper limit for each peer group of facilities with less than 101 beds shall be 110 percent of the weighted median. The upper limit for state designated teaching hospitals shall be established at 106 percent of the weighted median per diem for hospitals in their peer group.

State teaching hospitals owned or operated by the University of Kentucky and the University of Louisville Schools of Medicine shall be removed from the array in order to set the upper limit for other hospitals in the class. These state teaching hospitals shall be subject to the upper limits for facilities with 401 beds and up.

SECTION 102. ESTABLISHMENT OF UPPER LIMIT

Psychiatric hospitals shall not be peer grouped, but shall be in a separate array of psychiatric hospitals only.

Except as indicated in Section 101, the operating cost per diem and the capital cost per diem shall be limited to the prior year's rate per diem increased by one and one-half times the DRI average rate of inflation.

SECTION 102A. PAYMENT FOR CHILDREN WITH EXCEPTIONALLY HIGH COST OR LONG LENGTHS OF STAY

Section 102A. PAYMENT FOR CHILDREN WITH EXCEPTIONALLY HIGH COST OR LONG LENGTHS OF STAY

(a) CHILDREN UNDER AGE ONE (1)

For medically necessary hospital inpatient services provided to infants under the age of one (1) with exceptionally high cost or long lengths of stay, the payment shall be the same as item (b) of this section. These payments shall apply without regard to length of stay or number of admissions of the infants and regardless of whether they are in a disproportionate share hospital.

(b) CHILDREN UNDER AGE SIX (6) IN A DISPROPORTIONATE SHARE HOSPITAL

For medically necessary stays in disproportionate share hospitals, the allowable length of stay for children under age six (6) shall not be limited. After thirty (30) days from the date of admission (thirty (30) days from the date of the mother's discharge in the case of newborns), the facility shall be paid a per diem equal to 110 percent of their normal per diem. During the initial thirty (30) days, the facility shall be paid its normal per diem. They payment rate shall be based on the facility's prospective rate in effect for the period billed.

SECTION 102B. REVIEW OF DISPROPORTIONATE SHARE HOSPITAL CLASSIFICATION

Except as otherwise specified in this section, classification of disproportionate share hospitals shall be made prospectively prior to the beginning of each universal rate year. Classification, once determined by the department, shall not be revised for that rate year except that for psychiatric hospitals not previously determined to meet disproportionate share hospital status due to failure to meet the one (1) percent minimum Medicaid occupancy requirement, the department shall also accept no more frequently than once each calendar year a patient census submitted by the hospital showing adequate Medicaid occupancy with the subsequent classification to be effective for the balance of the calendar year.

Psychiatric hospitals with Medicaid utilization of thirty-five (35) percent or higher shall have an upper limit set at 115 percent of the weighted median per diem cost for psychiatric hospitals in the array.

SECTION 104. NEW PROVIDERS, CHANGE OF OWNERSHIP, OR MERGED HOSPITALS

Section 104. NEW PROVIDERS, CHANGE OF OWNERSHIP, OR MERGED FACILITIES

A. CHANGE OF OWNERSHIP

If a hospital undergoes a change of ownership, the new owner shall continue to be reimbursed at the prospective rate in effect. The new owner may appeal its rate subject to the provisions of Section 113. If at the time of the next prospective rate setting, the hospital does not have twelve (12) full months of actual costs in the fiscal year for which the cost report is submitted, the department shall use a partial fiscal year cost report to arrive at a prospective rate. This cost will be annualized and indexed appropriately.

B. NEWLY CONSTRUCTED OR NEWLY PARTICIPATING HOSPITALS

Until a fiscal year end cost report is available, newly constructed or newly participating hospitals shall submit an operating budget and projected number of patient days within thirty (30) days of receiving Medicaid certification. A prospective rate shall be set based on this data, not to exceed the upper limit for the class. This prospective rate shall be tentative and subject to settlement at the time the first audited fiscal year end report is available to the department. During

the projected rate year, the budget can be adjusted if indicated, and justified by the submittal of additional information.

C. MERGED FACILITIES

In the case of two (2) separate entities that merge into one (1) organization, the department shall:

1. Merge the latest available data used for rate setting;
2. Combine bed utilization statistics, creating new occupancy ratios;
3. Combine costs using the trending and indexing figures applicable to each entity in order to arrive at correctly trended and indexed costs;
4. Compute on a weighted average the rate of increase control applicable to each entity, based on the reported paid Medicaid days for each entity taken from the cost report previously used for rate setting;
5. If one (1) of the entities merging has disproportionate status and the other does not, retain for the merged entity the status of the entity which reported the highest number of Medicaid days paid;

SECTION 104. NEW PROVIDERS, CHANGE OF OWNERSHIP, OR MERGED HOSPITALS

6. Recognize appeals of the merged per diem rates in accordance with 907 KAR 1:671; and

7. Require each provider to submit a "Close of Business" Medicaid cost report for the period ended as of the day before the merger. This report shall be due from the provider within the time frame outlined in Section 109 of this manual. Medicaid cost reports for the period starting with the day of the merger and ending on the fiscal year end of the merged entity shall also be filed with the department in accordance with Section 109 of this manual.

SECTION 106. UNALLOWABLE COSTS

Section 106. UNALLOWABLE COSTS

A. The following costs shall not be considered allowable costs for Medicaid reimbursement:

1. Costs associated with political contributions;
2. The cost associated with legal fees for unsuccessful lawsuits against the cabinet. Legal fees relating to lawsuits against the cabinet shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or if otherwise agreed to by the parties involved or ordered by the court; and
3. The costs for travel and associated expenses outside the Commonwealth of Kentucky for purposes of conventions, meetings, assemblies, conferences or any related activities. However, costs (excluding transportation costs) for training or education purposes outside the Commonwealth of Kentucky shall be allowable costs. If these meetings are not educational, the cost (excluding transportation) shall be allowable if educational or training components are included.

SECTION 106. UNALLOWABLE COSTS

B. Since the costs referenced in this Section are currently not identified by the Medicare or Medicaid cost report, hospitals shall identify these unallowable costs on the Supplemental Medicaid Schedule KMAP-1. The Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted with the annual cost report. The purpose of the Supplemental Medicaid Schedule KMAP-1 is to identify these unallowable costs for exclusion from the prospective rate computation.

SECTION 108. RETROACTIVE SETTLEMENTS

Section 108. RETROACTIVE SETTLEMENTS

Revision of the prospective payment rate shall be made under the following circumstances:

A. If incorrect payments have been made due to computational errors, i.e., mathematical errors, discovered in the cost basis or establishment of the prospective rate. Omission of cost data shall not constitute a computational error;

B. If a determination of misrepresentation on the part of the facility is made by the program; or

C. If unaudited data is utilized to establish the universal rate, the rate shall be revised when the audited cost report is received in the department.

If circumstances (A) or (B) of this section occur, a settlement or revision shall be made only after the audited cost report is received. Factors which may affect the cost basis are costs utilized in determining Medicaid capital costs, i.e., total inpatient cost and total capital cost, and Medicaid allowable costs.

In accordance with Medicaid regulations at 42 CFR 447.271, Medicaid payments for inpatient hospital services shall be adjusted for the lesser of total prospective payments or customary charges at the end of the prospective rate year. There shall be no allowance made under the prospective system for the carry forward provision utilized by Medicare (Title XVIII) in regard to the lesser of prospective

SECTION 108. RETROACTIVE SETTLEMENTS

payments or customary charges for inpatient services. Similarly, the provisions allowed by Medicare for the recognition of a loss or a gain on the sale of a facility and depreciation carry forwards are not recognized under this prospective reimbursement system.

SECTION 109. COST REPORTING REQUIREMENTS

Section 109. COST REPORTING REQUIREMENTS

Each hospital participating in the program shall submit an annual cost report (HCFA 2552), including the Supplemental Medicaid Schedules, in the manner prescribed by the program as follows:

A. The reports shall be filed for the fiscal year used by the hospital;

B. The cost report shall be submitted within five (5) months after the close of the hospital's fiscal year; and

C. An extension shall not be granted by the program except in instances as follows:

1. When Medicare grants an extension, the Medicaid cost report shall be required simultaneous to the submittal of the Medicare cost report; or

2. When, catastrophic circumstances exist such as floods, fires or other equivalent occurrences, an additional 30 days for filing the cost report may be granted by the program;

C. If the filing date lapses and no extension has been granted, the program shall immediately suspend all payments to the hospital until an acceptable cost report is received.

SECTION 110. ACCESS TO SUBCONTRACTOR'S RECORDS

Section 110. ACCESS TO SUBCONTRACTOR'S RECORDS

If the hospital has a contract with a subcontractor, e.g., pharmacy, doctor, hospital, etc., for services costing or valued at $10,000 or more over a twelve (12) month period, the contract shall contain a clause giving the department access to the subcontractor's books. Access shall also be allowed for any subcontract between the subcontractor and an organization related to the subcontractor. The contract shall contain a provision allowing access in accordance with 907 KAR 1:672.

SECTION 111. AUDIT FUNCTION

Section 111. AUDIT FUNCTION

After the hospital has submitted the annual cost report, the program shall perform a limited desk review. The purpose of a desk review is to verify prior year cost to be used in setting the prospective rate. The Medicare intermediary shall be informed of any findings as a result of this desk review. Under a common audit agreement, the Medicare intermediary provides Medicaid with copies of any audits performed by Medicare (Title XVIII). However, the program may choose to audit even though Medicare does not.

SECTION 113. REIMBURSEMENT REVIEW APPEAL PROCESS

Section 113. REIMBURSEMENT REVIEW APPEAL PROCESS

A request for an administrative appeal under this section shall be in accordance with the following:

(1) The certificate of need for the equipment that is the subject matter of the appeal must have been placed in service during the state fiscal year immediately preceding the rate year under appeal.

(2) The following shall be included in the appeal request by the provider:

(a) Documentation that demonstrates that the costs related to the certificate of need have not been built into the rate;

(b) Operating and capital costs related to certificate of need for capital expenditure or capital costs related to a capital expenditure not requiring a certificate of need provided on a per diem basis as follows:

1. For a capital expenditure not requiring a certificate of need and used for the provision of inpatient services only, the total costs of the capital expenditure shall be divided by total allowable patient days to determine the *costs per day*.

2. For a capital expenditure requiring a certificate of need and used for the provision of inpatient services only, the total costs of the capital expenditure shall be divided by total allowable patient days to determine the *costs per day*.

SECTION 113. REIMBURSEMENT REVIEW APPEAL PROCESS

3. For a capital expenditure not requiring a certificate of need and for a capital expenditure requiring a certificate of need, that shall be used for inpatient and outpatient hospital services, the per diem costs shall be calculated by adjusting for outpatient utilization through an adjusted patient day calculation as follows:

a. Total allowable inpatient revenues shall be divided by total allowable inpatient days to determine the *inpatient revenue per day*;

b. Total outpatient revenues shall be divided by inpatient revenue per day to determine *outpatient equivalent days*;

c. Inpatient days and outpatient equivalent days determined in accordance with 3.a. and 3.b. of this section shall be added to determine *adjusted patient days*; and

d. Adjusted patient days shall be divided by total costs to determine *costs per day.*

(3) Total patient days shall be the total patient days submitted on the base year Medicare cost report on Worksheet S-3, Column 6, excluding nonallowable cost centers.

(4) Total inpatient revenue shall be the total inpatient revenue submitted on the base year Medicare cost report on Worksheet G-2, Column 1, Line 25, less nonallowable cost centers.

SECTION 113. REIMBURSEMENT REVIEW APPEAL PROCESS

(5) Total outpatient revenue shall be the total outpatient revenue submitted on the base year Medicare cost report on Worksheet G-2, Column 2, Line 25, less nonallowable cost centers.

(6) Operating costs shall include salaries associated with additional full time equivalents (FTE) added as a result of the certificate of need.

(7) Costs calculated in accordance with (2)b. of this section shall be the only adjustments to be considered by the department to the applicable operating and capital components of a hospital's per diem rate.

(8) The department shall adjust any relief granted under this section to the extent the relief is based on unaudited data, once the department is in possession of final audited data.

SECTION 117. SUPPLEMENTAL MEDICAID SCHEDULES AND INSTRUCTIONS

Section 117. SUPPLEMENTAL MEDICAID SCHEDULES AND INSTRUCTIONS

This section contains the supplemental Medicaid schedules and instructions which shall be filed by the provider with their annual cost report (HCFA 2552) and shall be used by the program for hospital rate setting purposes.

SECTION 118 KCHIP OR MEDICAID SCREENING FORM (DSH-001)

This section contains the screening form to be used by the provider to assess the patient's financial situation to determine if Medicaid or Kentucky Children's Health Insurance Program (KCHIP) may cover hospital expenses in accordance with Section 17 of 907 KAR 1:013.

DSH-001 *(Rev. 07/01)*

APPLICATION FOR DISPROPORTIONATE SHARE HOSPITAL PROGRAM (DSH)

SECTION I. Individual Information

The following information is required to determine if an individual who requests or has already received hospital services is eligible for Disproportionate Share Hospital services or should be referred to the Department for Community Based Services (DCBS) to officially apply for Medicaid or KCHIP. Refer **all uninsured children aged 19 and under** to the DCBS office in the county of the individual's residence for a KCHIP eligibility determination.

1. Today's Date:_____

2. Patient Name:_____

3. Street Address:_____

4. City:_____ State:_____ Zip Code:_____

5. Social Security Number: ☐☐☐ ☐☐ ☐☐☐☐

6. Date of Birth: ____/___/_____ 7. Patient Sex:_____

8. Home Phone: _____ 9. Work Phone:_____

10. Date(s) hospital services provided: ____/___ /_____ - ____/____/____

11. Married/Single:_____ 12. Name of Spouse:_____

13. Is the patient pregnant? ☐ Yes ☐ No. If yes, refer the patient to DCBS for a Medicaid eligibility determination.

14. Is the patient a resident of Kentucky?
"RESIDENT" IS DEFINED AS A PERSON LIVING IN KENTUCKY AND WHO IS NOT RECEIVING PUBLIC ASSISTANCE IN ANOTHER STATE.
Yes ☐ No☐

If the answer to question 14 is **yes**, go to question 15. If the answer to question 14 is **no, advise the patient that he/she does not meet criteria for eligibility for DSH and complete Section V.**

15. List the name, social security no., relationship, and age of each person living in the household.

Household Members

Name	Social Security #	Relationship	Age

16. Does the individual have dependent children living in the home ? Yes ☐ No ☐

(a) **If the answer to question 16 is YES**, refer the individual to DCBS for Medicaid;

(b) If the answer to question 16 is **NO**, refer the individual to DCBS for Medicaid **ONLY IF** the individual has **NOT** received a denial from Medicaid within 30 days; **or,**

(c) If the- individual who has no children less than 18 years of age, claims to be **disabled**, **refer** the individual to the **Social Security Administration** to apply for SSI.

17. Income Information:

Patient/Responsible Party Employer_____Spouse Employer_____
Work Phone_____
Total Gross Monthly Income:_____
Other Income:
Unemployment_____Child Support_____
Soc. Sec._____ Workers Comp_____
SSI_____Other_____

Total Family Unit Gross Monthly Income: $_____

18. Insurance Information:

Health/Life Insurance:_____ Phone#_____

Policy #_____Group#_____

Policy Holder_____Relation to Patient_____

19. List the patient's countable resources below. Countable resources include: a checking account, savings account, stock, bond, mutual fund, certificate of deposit, money market account.

Countable Resources

	Bank Name	**Balance/Value**
Checking		
Savings		
Certificate Of deposit		
Money market		
Mutual fund		
Stocks		
Bonds		
Other		

***Total Health Bills Owed: $_____**

Total Resource: $_____

***Note:** COUNTABLE RESOURCES SHALL BE REDUCED BY UNPAID MEDICAL EXPENSES OF THE FAMILY UNIT TO ESTABLISH ELIGIBILITY.

Other Information:

Was date of service related to an auto accident?_____

SECTION II. Hospital Indigent Care Criteria

(1) An individual must meet all of the following conditions:
(a) The individual is a resident of Kentucky.
(b) The individual is **not eligible** for Medicaid.
(c) The individual is **not** covered by a 3rd party payor.
(d) The individual is **not** in the custody of a unit of government which is responsible for coverage of the acute care needs of the individual.
(e) The individual meets the following income and resource criteria:

Household Size	Resource Limit	100% of the Poverty Level (Monthly Income Limit)*	100% of the Poverty Level (Annual Income Limit)*
1	$2,000.00	$715.83	$ 8,590.00
2	$4,000.00	$967.50	$11,610.00
3	$4,050.00	$1,219.17	$14,630.00
4	$4,100.00	$1,470.83	$17,650.00
5	$4,150.00	$1,722.50	$20,670.00

*Note- Income limits are effective March 1, 2001

(2) **All income** of a family unit is to be counted and a family unit includes:
(a) The individual;
(b) The individual's spouse who lives in the home;
(c) A parent or parents, of a minor child, who lives in the home;
(d) All minor children who live in the home.
(3) Related and nonrelated household member(s) who do not fall into one of the groups listed above shall be considered a separate family unit.
(4) **Countable resources are limited to** cash, checking and savings accounts, stocks, bonds, certificates of deposit, and money market accounts.
(5) Countable resources may be reduced by unpaid medical expenses of the family unit to determine eligibility.

SECTION III. Certifying Accuracy of Information

I hereby agree to furnish the Hospital all necessary information to allow them to determine my need to receive financial assistance for health care services received. I agree that the Hospital will be provided with or may obtain all documents necessary to verify my current income, employment status, and resources, and that failure to supply requested information within **ten** (10) working days is grounds for denial of my application for assistance. I also agree to notify the Hospital immediately of any change of address, telephone number, employment status, or income.

I agree to allow the Hospital representative to determine eligibility and pursue state and federal assistance with Medicaid, KCHIP and DSH.

I certify that the information provided on this application is correct to the best of my knowledge and belief. I understand that if I give false information or withhold information in accepting assistance, I may be subject to prosecution for fraud. I understand that I have a right to request a fair hearing if I am dissatisfied with any action taken on my application. I understand that I must contact the hospital to make a hearing request.

_____ _____
Individual or Responsible Party's Signature Date

_____ _____
Hospital Employee Signature Date

Does the individual appear to qualify for Medicaid or KCHIP? Yes ☐ No ☐

If yes, then refer the individual to the DCBS office in the county of the individual's residence. The individual should take a copy of this form with him/her to the DCBS office.

SECTION IV. Refusal to Apply for Medicaid

The individual or his responsible party shall sign below if he refuses to apply for Medicaid.

I refuse to apply for Medicaid or KCHIP coverage. I understand that this refusal may result in me being billed for any services performed.

_____ _____

Individual or Responsible Party's Signature Date

SECTION V. Indigent Care Denial

The individual does not meet the criteria for indigent care. The individual may request a fair hearing regarding this determination within 30 days of this determination. The hospital shall conduct a fair hearing within 30 days of receiving the individual's hearing request.

_____ _____

Hospital Employee Signature Date

RETAIN A COPY OF THIS APPLICATION IN THE PATIENT'S RECORDS.
THIS DETERMINATION IS VALID FOR A PERIOD OF SIX MONTHS UNLESS THE INDIVIDUAL'S FINANCIAL SITUATION CHANGES.